DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington

To: Pharmacists
All Prescribers
Nursing Home Administrators
Managed Care Organizations

From: Douglas Porter, Assistant Secretary
Health and Recovery Services
Administration (HRSA)

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For information, contact Provider Relations at: 800.562.3022, option 2 or http://maa.dshs.wa.gov/contact/prucontact.asp or visit the pharmacy web site at: http://maa.dshs.wa.gov/pharmacy

Subject: Prescription Drug Program: ESA Guidelines for Appropriate Use, Additions/Changes to the Washington PDL and EPA Criteria

Effective for dates of service on and after October 1, 2007, unless otherwise specified, HRSA will implement the following changes to the Prescription Drug Program:

- Additions to the Washington Preferred Drug List (PDL);
- Changes to the Washington PDL;
- Expedited Prior Authorization (EPA) Drug Additions;
- EPA Code and Criteria Additions;
- EPA Deletions;
- Additions to the List of Limitations on Certain Drugs;
- Changes to the List of Limitations on Certain Drugs; and
- Erythropoiesis Stimulating Agents Guidelines for Appropriate Use.

Additions to the Washington Preferred Drug List (PDL)

The following drug classes are being added to the Washington PDL:

Drug Class	Preferred Drugs	Nonpreferred Drugs
Hepatitis C drugs (pegylated interferons)	Pegasys® *(peginterferon alfa-2a)*	PegIntron® *(peginterferon alfa-2b)*
Newer Sedative/Hypnotics	**Generic:** zolpidem* *EPA required	**Brand:** Ambien /CR® *(zolpidem tartrate)** Lunesta® *(eszopiclone)** Sonata® *(zaleplon)** *EPA required

Changes to the Washington Preferred Drug List (PDL)

Changes to preferred and/or non-preferred drugs on the Washington PDL are highlighted in yellow:

Drug Class	Preferred Drugs	Nonpreferred Drugs
Antiplatelets (*Not subject to TIP. See pg. M.1.)	**Generic:** clopidogrel* **Brand:** Aggrenox® (*aspirin/dipyridamole*)* Plavix® (*clopidogrel bisulfate*)* *EPA required	**Generic:** ticlopidine **Brand:** Ticlid® (*ticlopidine*)
Attention Deficit/ Hyperactivity Disorder (*Not subject to TIP. See pg. M.1.)	**Generic:** amphetamine salt combo dextroamphetamine dextroamphetamine SA methylphenidate methylphenidate SA Methylin® (*methylphenidate HCl*) tablet Methylin ER® *(methylphenidate HCl)* **Brand:** Adderall XR® *(amphetamine salt combo)* Concerta® *(methylphenidate HCl)* Strattera® *(atomoxetine HCl)*	**Generic:** pemoline **Brand:** Adderall® *(amphetamine salt combo)* Daytrana™ (*methylphenidate HCl*) transdermal patch** Dexedrine® *(d-amphetamine)* Dexedrine SA® *(d-amphetamine)* Dextrostat® *(d-amphetamine)* Focalin® *(dexmethylphenidate)* Focalin XR® *(dexmethylphenidate)* Metadate CD™ *(methylphenidate HCl)* Metadate ER™ *(methylphenidate HCl)* Methylin® *(methylphenidate HCl)* chewable/solution Ritalin® *(methylphenidate HCl)* Ritalin LA® (*methylphenidate HCl)* Ritalin SR® *(methylphenidate HCl)* Vyvanse™ (*lisdexamfetamine dimesylate*)** **Not subject to DAW-1 override.

Drug Class	Preferred Drugs	Nonpreferred Drugs
Calcium Channel Blockers	**Generic:** amlodipine diltiazem /XR felodipine nifedipine ER verapamil /XR **Brand:**	**Generic:** nicardipine nifedipine **Brand:** Adalat® /CC (*nifedipine*) Calan® /SR (*verapamil*) Cardene® /SR (*nicardipine*) Cardizem® /CD/LA/SR (*diltiazem*) Cartia XT® (*diltiazem*) Dilacor® XR (*diltiazem*) Diltia XT® (*diltiazem*) DynaCirc® /CR (*isradipine*) Isoptin® /SR (*verapamil*) Norvasc® (*amlodipine*) Plendil® (*felodipine*) Procardia® /XL (*nifedipine*) Sular® (*nisoldipine*) Taztia XT® (*diltiazem*) Tiazac® (*diltiazem*) Vascor® (*bepridil*) Verelan® /PM (*verapamil*)

Drug Class	Preferred Drugs	Nonpreferred Drugs
Estrogens	**Generic:** estradiol tablets **Brand:** Menest® (*esterified estrogens*) Premarin® cream (*conjugated equine estrogen vaginal cream*)	**Generic:** estradiol transdermal patch estropipate **Brand:** Alora® (*estradiol*) transdermal Cenestin® (*synthetic conjugated estrogens*) Climara® (*estradiol*) transdermal Elestrin™ (*estradiol*) gel** Esclim® (*estradiol*) transdermal Estrace® (*estradiol*) oral/vaginal Estraderm® (*estradiol*) transdermal Estring® (*estradiol*) vaginal ring Femring® (*estradiol*) vaginal ring Femtrace® (*estradiol*) tablet** Ogen® (*estropipate*) Premarin® (*conjugated equine estrogens*) oral Vagifem® (*estradiol*) vaginal tablets Vivelle® /DOT (*estradiol*) transdermal **Not subject to DAW-1 override or TIP.

Drug Class	Preferred Drugs	Nonpreferred Drugs
Inhaled Corticosteroids	**Generic:** **Brand:** Aerobid/Aerobid-M® (*flunisolide MDI*) Asmanex Twisthaler® (*mometasone fumarate DPI*) Azmacort® (*triamcinolone acetonide MDI*) Flovent® (*fluticasone propionate MDI*) Flovent® HFA (*fluticasone propionate HFA*) Flovent Rotadisk® (*fluticasone propionate DPI*) Qvar® (*beclomethasone dipropionate MDI*) Pulmicort Respules® (*budesonide inhalation suspension*) Pulmicort Turbuhaler®/Flexhaler® *(budesonide DPI)*	**Generic:** **Brand:** Vanceril® *(beclomethasone dipropionate MDI)*
Nasal Corticosteriods	**Generic:** **Brand:** Nasacort AQ® *(triamcinolone acetonide)* Nasonex® (*mometasone furoate*)* *EPA required	**Generic:** flunisolide fluticasone **Brand:** Beconase® *(beclomethasone dipropionate)* Beconase AQ® *(beclomethasone dipropionate)* Flonase® *(fluticasone propionate)* Nasacort® *(triamcinolone acetonide)* Nasarel® *(flunisolide)* Rhinocort® (*budesonide*) Rhinocort Aqua® (*budesonide*) Veramyst™ (*fluticasone*)** **Not subject to DAW-1 override or TIP.

Drug Class	Preferred Drugs	Nonpreferred Drugs
Skeletal Muscle Relaxants	**Generic:** baclofen cyclobenzaprine methocarbamol tizanidine	**Generic:** carisoprodol chlorzoxazone orphenadrine **Brand:** Dantrium® (*dantrolene*) Flexeril® (*cyclobenzaprine*) Lioresal® (*baclofen*) Norflex® (*orphenadrine*) Parafon Forte® (*chlorzoxazone*) Robaxin® (*methocarbamol*) Skelaxin® (*metaxalone*) Soma® (*carisoprodol*) Zanaflex® (*tizanidine*)
Targeted Immune Modulators	**Generic:** **Brand:** Enbrel® (*etanercept)** Humira® *(adalimumab)** Remicade® (*infliximab)** *EPA required	**Generic:** **Brand:** Amevive® *(alefacept)** Kineret® *(anakinra)** Orencia® *(abatacept)** Raptiva® *(efalizumab)** Rituxan® *(rituximab)** *EPA required

Expedited Prior Authorization (EPA) Drug Additions

HRSA is adding the following drugs to the EPA list:

Drug	Code	Criteria
Amevive® *(alefacept)*	018	Treatment of plaque psoriasis when prescribed by a rheumatologist or dermatologist in patients who are candidates for systemic or phototherapy. Maximum dose of 7.5mg intravenous bolus or 15mg intramuscular injection once a week.
Exforge® *(amlodipine/ valsartan)*	093	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor, and must currently be on amlodipine and/or valsartan.
Orencia® *(abatacept)*	044	Treatment of rheumatoid arthritis when prescribed by a rheumatologist in patients who have tried and failed one or more DMARDs. Maintenance dose is limited to 1000mg as an intravenous infusion every 4 weeks after the initial 4 weeks of therapy (allowed to be dosed every 2 weeks during first 4 weeks of therapy).

Drug	Code	Criteria
Rituxan® *(rituximab)*	054	Treatment of non-Hodgkin's lymphoma.
	055	Treatment of rheumatoid arthritis when prescribed by a rheumatologist in combination with methotrexate in patients who have failed another tumor necrosis factor (TNF) inhibitor. Limited to 2 1000mg intravenous infusions separated by 2 weeks.
Zolpidem	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.

EPA Code and Criteria Additions

HRSA is adding the following new codes and criteria to drugs already on the EPA list:

Drug	Code	Criteria
Humira® *(adalimumab)*	022	Treatment of Crohn's disease when prescribed by a gastroenterologist for patients who have tried and failed conventional therapy. 160mg subcutaneous dose to start, 80mg at week 2, and then maximum dose of 40mg subcutaneously every other week.
Lyrica®	035	Treatment of post-herpetic neuralgia.
(*pregabalin*)	036	Treatment of seizures.
	063	Treatment of diabetic peripheral neuropathy.
	066	Treatment of fibromyalgia.
Remicade® *(infliximab)*	046	Treatment of ulcerative colitis when prescribed by a gastroenterologist in those patients who have tried and failed conventional therapy. Maximum maintenance dose is 5mg/kg given every 8 weeks after the induction regimen of 5mg/kg given at week 2 and week 6 of therapy.

Changes to EPA Criteria

HRSA is making the following changes to EPA criteria for drugs already on the EPA list:

Drug	Code	Criteria
Ambien® *(zolpidem tartrate)*	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Ambien CR® *(zolpidem tartrate)*	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Lunesta® *(eszopiclone)*	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Sonata® *(zaleplon)*	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.

EPA Deletions

HRSA is removing Rozerem®, and the following codes and criteria for Humira® and Remicade Injection® from the EPA list:

Drug	Code	Criteria
Humira® *(adalimumab)*	026	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist for patients who have tried and failed one or more DMARD. Dose not to exceed 40mg subcutaneously every 2 weeks if patient is also receiving methotrexate, or up to 40mg subcutaneously every week if patient is not receiving methotrexate concomitantly.
	028	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients who have tried and failed one or more DMARD. Dose not to exceed 40mg subcutaneously every 2 weeks if patient is also receiving methotrexate, or up to 40mg subcutaneously every week if patient is not receiving methotrexate concomitantly.
Remicade Injection® *(infliximab)*	023	Treatment of Crohn's disease or ulcerative colitis when prescribed by a gastroenterologist in those patients who have tried and failed conventional therapy. Maximum dose is 10mg/kg given every 4 weeks.
Rozerem® *(ramelteon)*	006	Treatment of insomnia. Drug therapy is limited to 10 units in 30 days.

Additions to the List of Limitations on Certain Drugs

The following drug is being added to the List of Limitations on Certain Drugs:

Drug	Limitations
Allegra® *(fexofenadine oral suspension)*	20 mls per day

Changes to the List of Limitations on Certain Drugs

HRSA is changing the limits for the following drugs:

Drug	Limitations
Ambien® *(zolpidem tartrate)*	30 tablets/30 days for first fill, then 10 tablets/30 days
Ambien CR® *(zolpidem tartrate)*	30 tablets/30 days for first fill, then 10 tablets/30 days
Lunesta® *(eszopiclone)*	30 tablets/30 days for first fill, then 10 tablets/30 days
Rozerem® *(ramelteon)*	30 tablets/30 days for maximum of 90 days
Sonata® *(zaleplon)*	30 tablets/30 days for first fill, then 10 tablets/30 days
Zolpidem	30 tablets/30 days for first fill, then 10 tablets/30 days

Erythropoiesis Stimulating Agents' Guidelines for Appropriate Use

Based on Food and Drug Administration (FDA) labeling, and the Centers for Medicare and Medicaid Services' (CMS) and the Washington State Drug Utilization Review (DUR) Board recommendations, **HRSA is publishing recommended guidelines for appropriate use of erythropoiesis stimulating agents (ESA).** Please use these guidelines when it is medically necessary to use the ESAs:

- **Appropriate monitoring for all ESAs include:**
  - ✓ Hemoglobin is < 12 mg/dL;
  - ✓ Patient has adequate iron stores (ferritin ≥ 100 ng/mL and transferring saturation ≥ 20%); and
  - ✓ Patient has adequate blood pressure control.
- **Epogen and Procrit have the following FDA approved indications:**
  - ✓ Anemia associated with chronic kidney disease (both dialysis and non-dialysis patients);
  - ✓ Anemia associated with chemotherapy in cancer patients with non-myeloid malignancies;
  - ✓ Anemia associated with zidovudine therapy in patients infected with human immunodeficiency virus (HIV); and
  - ✓ Management of anemia to reduce allogeneic blood transfusion in surgery patients.
- **Aranesp has the following FDA approved indications:**
  - ✓ Anemia associated with chronic kidney disease (both dialysis and non-dialysis patients); and
  - ✓ Anemia associated with chemotherapy in cancer patients with non-myeloid malignancies.

Billing Instructions Replacement Pages

Attached are replacement pages H.7-H.22, and N.1-N.14 for HRSA's current *Prescription Drug Program Billing Instructions*.

How can I get HRSA's provider documents?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

Drug	Code	Criteria
Accutane® *(isotretinoin)*		Must not be used by patients who are pregnant or who may become pregnant while undergoing treatment. The following conditions must be **absent**: a) Paraben sensitivity; b) Concomitant etretinate therapy; and c) Hepatitis or liver disease.
	001	Diagnosis of severe (disfiguring), recalcitrant cystic acne, unresponsive to conventional therapy.
	002	Diagnosis of severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy.
	003	Diagnosis of severe keratinization disorders when prescribed by, or in consultation with, a dermatologist.
	004	Prevention of skin cancers in patients with xeroderma pigmentosum.
	005	Diagnosis of mycosis fungoides (T-cell lymphoma) unresponsive to other therapies.
Aggrenox® *(aspirin/dipyridamole)*	037	To reduce the risk of stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis, and all of the following: a) The patient has tried and failed aspirin or dipyridamole alone; and b) The patient has no sensitivity to aspirin.
Aloxi® **Injection** (*palonosetron)*	129	Administered as a single dose in conjunction with cancer chemotherapy treatment.

Drug	Code	Criteria
Altace® *(ramipril)*	020	Patients with a history of cardiovascular disease.
Ambien® *(zolpidem tartrate)*	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Ambien CR® *(zolpidem tartrate)*	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Amevive® *(alefacept)*	018	Treatment of plaque psoriasis when prescribed by a rheumatologist or dermatologist in patients who are candidates for systemic or phototherapy. Maximum dose of 7.5mg intravenous bolus or 15mg intramuscular injection once a week.
Amitiza® *(lubiprostone)*	007	Treatment of chronic constipation. Must have tried and failed a less costly alternative.
Angiotensin Receptor Blockers (ARBs)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor.
Atacand® *(candesartan cilexetil)* **Atacand HCT**® *(candesartan cilexetil/HCTZ)* **Avalide**® *(irbesartan/HCTZ)* **Avapro**® *(irbesartan)* **Benicar**® *(olmesartan medoxomil)* **Benicar HCT**® *(olmesartan medoxomil/HCTZ)* **Cozaar**® *(losartan potassium)* **Diovan**® *(valsartan)* **Diovan HCT**® *(valsartan/HCTZ)* **Hyzaar**® *(losartan potassium/HCTZ)* **Micardis**® *(telmisartan)* **Micardis HCT**® *(telmisartan/HCTZ)* **Teveten**® *(eprosartan mesylate)* **Teveten HCT**® *(eprosartan mesylate/HCTZ)*		
Anzemet® *(dolasetron mesylate)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
Arava® *(leflunomide)*	034	Treatment of rheumatoid arthritis when prescribed by a rheumatologist at a loading dose of 100mg per day for three days and then up to 20mg daily thereafter.
Avinza® *(morphine sulfate)*	040	Diagnosis of cancer-related pain.

Drug	Code	Criteria
Calcium w/Vitamin D Tablets	126	Confirmed diagnosis of osteoporosis, osteopenia, or osteomalacia.
Campral® *(acamprosate sodium)*	041	Diagnosis of alcohol dependency. Must be used as adjunctive treatment with a Division of Alcohol and Substance Abuse (DASA) state-certified intensive outpatient chemical dependency treatment program. See WAC 388-805-610. Treatment is limited to 12 months. The patient must also meet all of the following criteria: a) Must have finished detoxification and must be abstinent from alcohol before the start of treatment; b) Must not be a poly-substance abuser; and c) Must be able to clear the drug renally (creatinine clearance greater than 30 ml/min). **Note:** A Campral authorization form [DSHS 13-749] must be completed and kept on file with the pharmacy before the drug is dispensed. To download a copy, go to: http://www1.dshs.wa.gov/msa/forms/eforms.html.
Celebrex®	062	All of the following must apply: a) An absence of a history of ulcer of gastrointestinal bleeding; and b) An absence of a history of cardiovascular disease.
Clarinex® syrup *(desloratadine)*	012	Patient is at least 6 months, but less than 2 years, of age.
Copegus® *(ribavirin)*	010	Diagnosis of chronic hepatitis C virus infection in patients 18 years of age or older. Patient must be on concomitant alpha interferon or pegylated alpha interferon therapy (not to be used as monotherapy).
Coreg® *(carvedilol)*	057	Diagnosis of congestive heart failure.
Dolophine® *(methadone HCl)*	040	Diagnosis of cancer-related pain.

Drug	Code	Criteria
Duragesic® *(fentanyl)*	040	Diagnosis of cancer-related pain.
Enbrel® *(etanercept)*	017	Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD).
	024	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more DMARD.
	025	Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Dose not to exceed 50mg subcutaneously twice weekly for the first three months of therapy and not to exceed 50mg weekly thereafter.
Exforge® *(amlodipine/ valsartan)*	093	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor, and must currently be on amlodipine and/or valsartan.
Gabitril® *(tiagabine HCl)*	036	Treatment of seizures.
Geodon® IM Injection *(ziprasidone mesylate)*	058	All of the following must apply: a) Diagnosis of acute agitation associated with schizophrenia; b) Patient is 18 years of age or older; and c) Maximum dose of 40mg per day and no more than 3 consecutive days of treatment.
Note: Because Geodon® prolongs the QT interval (< Seroquel® > Risperdal® > Zyprexa®), it is contraindicated in patients with a known history of QT prolongation (including a congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval.		

Drug	Code	Criteria
Glycolax Powder® *(polyethylene glycol)*	021	Treatment of occasional constipation. Must have tried and failed a less costly alternative.
Humira® *(adalimumab)*	022	Treatment of Crohn's disease when prescribed by a gastroenterologist for patients who have tried and failed conventional therapy. 160mg subcutaneous dose to start, 80mg at week 2, and then maximum dose of 40mg subcutaneously every other week.
	~~026~~	~~Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist for patients who have tried and failed one or more DMARD. Dose not to exceed 40mg subcutaneously every 2 weeks if patient is also receiving methotrexate, or up to 40mg subcutaneously every week if patient is not receiving methotrexate concomitantly.~~
	~~028~~	~~Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients who have tried and failed one or more DMARD. Dose not to exceed 40mg subcutaneously every 2 weeks if patient is also receiving methotrexate, or up to 40mg subcutaneously every week if patient is not receiving methotrexate concomitantly.~~
Infergen® *(interferon alphcon-1)*	134	Treatment of chronic hepatitis C in patients 18 years of age and older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.
Intron A® *(interferon alpha-2b recombinant)*	030	Diagnosis of hairy cell leukemia in patients 18 years of age and older.
	031	Diagnosis of recurring or refractory condyloma acuminate (external genital/perianal area) for intralesional treatment in patients 18 years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients 18 years of age and older.
	033	Diagnosis of chronic hepatitis B in patients 1 year of age and older.
	107	Diagnosis of malignant melanoma in patients 18 years of age and older.
	109	Treatment of chronic hepatitis C in patients 18 years of age and older.
	135	Diagnosis of follicular non-Hodgkin's lymphoma in patients 18 years of age and older.

Drug	Code	Criteria
Kadian® *(morphine sulfate)*	040	Diagnosis of cancer-related pain.
Keppra™ *(levetiracetam)*		See criteria for Gabitril®.
Kineret® Injection *(anakinra)*	029	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients 18 years of age and older who have tried and failed one or more DMARD. Daily dose not to exceed 100mg subcutaneously.
Kytril® *(granisetron HCl)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.
Lamisil® *(terbinafine HCl)*		Treatment of onychomycosis for up to 12 months is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis and requiring systemic antibiotic therapy;
	051	Peripheral vascular disease; or
	052	Patient is immunocompromised.
Levorphanol	040	Diagnosis of cancer-related pain.
Lotrel® *(amlodipine-besylate/ benazepril)*	038	Treatment of hypertension as a second-line agent when blood pressure is not controlled by any: a) ACE inhibitor alone; or b) Calcium channel blocker alone; or c) ACE inhibitor and a calcium channel blocker as two separate concomitant prescriptions.
Lunesta™ *(eszopiclone)*	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.

Drug	Code	Criteria
Lyrica® (*pregabalin*)	035	Treatment of post-herpetic neuralgia.
	036	Treatment of seizures.
	063	Treatment of diabetic peripheral neuropathy.
	066	Treatment of fibromyalgia.
Miralax® *(polyethylene glycol)*		See criteria for Glycolax Powder®.
MS Contin® *(morphine sulfate ER)*	040	Diagnosis of cancer-related pain.
Nasonex® (*mometasone furoate*)	015	Patient is 2 to 6 years of age.
Naltrexone		See criteria for ReVia®.
Nephrocaps®, **Nephro-Fer**®, **Nephro-vite**®, **Nephro-Vite**® **Rx, Nephro-vite**® **+Fe, and Nephron**® **FA**	096	Treatment of patients with renal disease.
Neurontin® *(gabapentin)*	035	Treatment of post-herpetic neuralgia.
	036	Treatment of seizures.
	063	Treatment of diabetic peripheral neuropathy.

Drug	Code	Criteria
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	141	An absence of a history of ulcer or gastrointestinal bleeding.
Arthrotec® *(diclofenac/misoprostol)* diclofenac potassium diflunisal diclofenac sodium SR/ER/EC etodolac /XL fenoprofen flurbiprofen ibuprofen ibuprofen/hydrocodone (Vicoprofen®) indomethacin /SA ketoprofen /SA ketorolac meclofenamate meloxicam nabumetone naproxen /EC naproxen sodium /ER oxaprozin piroxicam Ponstel® *(mefenamic acid)* salsalate sulindac tolmetin		
Opana ER® *(Oxymorphone HCl ER)*	040	Diagnosis of cancer-related pain.
Orencia® *(abatacept)*	044	Treatment of rheumatoid arthritis when prescribed by a rheumatologist in patients who have tried and failed one or more DMARDs. Maintenance dose is limited to 1000mg as an intravenous infusion every 4 weeks after the initial 4 weeks of therapy (allowed to be dosed every 2 weeks during first 4 weeks of therapy).

Drug	Code	Criteria
Oxandrin® *(oxandrolone)*		Before any code is allowed, there must be an absence of all of the following: a) Hypercalcemia; b) Nephrosis; c) Carcinoma of the breast; d) Carcinoma of the prostate; and e) Pregnancy.
	110	Treatment of unintentional weight loss in patients who have had extensive surgery, severe trauma, chronic infections (such as AIDS wasting), or who fail to maintain or gain weight for no conclusive pathophysiological cause.
	111	To compensate for the protein catabolism due to long-term corticosteroid use.
	112	Treatment of bone pain due to osteoporosis.
OxyContin® *(oxycodone HCI)*	040	Diagnosis of cancer-related pain.
Parcopa® *(carbidopa/levodopa)*	049	Diagnosis of Parkinson's disease and one of the following: a) Must have tried and failed generic carbidopa/levodopa; or b) Be unable to swallow solid oral dosage forms.
PEG-Intron® *(peginterferon alpha 2b)*	109	Treatment of chronic hepatitis C in patients 18 years of age or older.
Pegasys® *(peginterferon alpha-2a)*	109	Treatment of chronic hepatitis C in patients 18 years of age or older.
Plavix® *(clopidogrel bisulfate)*	116	When used in conjunction with stent placement in coronary arteries. Supply limited to 9 months after stent placement.
	136	For use in patients with atherosclerosis documented by recent myocardial infarction, recent stroke, or established peripheral artery disease and have failed aspirin. A patient that is considered an aspirin failure has had an atherosclerotic event (MI, stroke, intermittent claudication) after the initiation of once-a-day aspirin therapy.

Drug	Code	Criteria
Pravastatin	039	Patient has a clinical drug-drug interaction with other statin-type cholesterol-lowering agents.
Prevacid® SoluTab™ *(lansoprazole)*	050	Inability to swallow oral tablets or capsules.
Pulmozyme® *(dornase alpha)*	053	Diagnosis of cystic fibrosis and the patient is 5 years of age or older.
Raptiva® *(efalizumab)*	027	Treatment of plaque psoriasis when prescribed by a dermatologist for patients 18 years or older. Weekly dose is not to exceed 200mg subcutaneously.
Rebetol® *(ribavirin)*		See criteria for Copegus®.
Rebetron® *(ribaviron /interferon alpha-2b, recombinant)*	008	Treatment of chronic hepatitis C in patients with compensated liver disease who have relapsed following alpha interferon therapy.
	009	Treatment of chronic hepatitis C in patients with compensated liver disease.
Remicade Injection® *(infliximab)*	~~023~~	~~Treatment of Crohn's disease or ulcerative colitis when prescribed by a gastroenterologist in those patients who have tried and failed conventional therapy. Maximum dose is 10mg/kg given every 4 weeks.~~
	046	Treatment of ulcerative colitis when prescribed by a gastroenterologist in those patients who have tried and failed conventional therapy. Maximum maintenance dose is 5mg/kg given every 8 weeks after the induction regimen of 5mg/kg given at week 2 and week 6 of therapy.
Rena-Vite® **Rena-Vite RX®** *(folic acid/vit B comp W-C)*	096	Treatment of patients with renal disease.

Drug	Code	Criteria
ReVia® *(naltrexone HCl)*	067	Diagnosis of past opioid dependency or current alcohol dependency. Must be used as adjunctive treatment within a state-certified intensive outpatient chemical dependency treatment program. See WAC 388-805-610. For maintenance of opioid-free state in a detoxified person, treatment may be started only after a minimum of 7-10 days free from opioid use. Treatment period must be limited to 12 weeks or less, and the patient must have an absence of all of the following: a) Acute liver disease; and b) Liver failure; and c) Pregnancy.
Note: A ReVia® (*Naltrexone*) Authorization Form [DSHS 13-677] must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:** http://www1.dshs.wa.gov/msa/forms/eforms.html		
Ribavirin		See criteria for Copegus®.
Risperdal® **Consta**® **IM Injection** *(risperidone microspheres)*	059	All of the following must apply: a) There is an appropriate DSM IV diagnosis with a psychotic disorder; b) Patient is 18 to 65 years of age; c) Patient has established tolerance to oral risperidone prior to initiating Risperdal Consta®; and d) Total daily dose is not more than 9mg/day (injectable plus oral at an injectable conversion rate of 25 mg every two weeks IM = 2 mg every day oral).
Rituxan® *(rituximab)*	054	Treatment of non-Hodgkin's lymphoma.
	055	Treatment of rheumatoid arthritis when prescribed by a rheumatologist in combination with methotrexate in patients who have failed another tumor necrosis factor (TNF) inhibitor. Limited to 2 1000mg intravenous infusions separated by 2 weeks.
Roferon-A® *(interferon alpha-2a recombinant)*	030	Diagnosis of hairy cell leukemia in patients **18** years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients **18** years of age and older.
	080	Diagnosis of chronic phase, Philadelphia chromosome (Ph) positive chronic myelogenous leukemia (CML) when treatment started within one year of diagnosis.
	109	Treatment of chronic hepatitis C in patients **18** years of age and older.

Drug	Code	Criteria
~~**Rozerem**®~~ ~~*(ramelteon)*~~		~~See criteria for Ambien®.~~
Sonata® *(zaleplon)*	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Soriatane® *(acitretin)*	064	Treatment of severe, recalcitrant psoriasis in patients **16** years of age and older. Prescribed by, or in consultation with, a dermatologist, and the patient must have an **absence** of all of the following: a) Current pregnancy or pregnancy which may occur while undergoing treatment; and b) Hepatitis; and c) Concurrent retinoid therapy.
Sporanox® *(itraconazole)*		Must not be used for a patient with cardiac dysfunction such as congestive heart failure.
	047	Treatment of systemic fungal infections and dermatomycoses.
		Treatment of onychomycosis for up to 12 months is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis **and** requiring systemic antibiotic therapy;
	051	Peripheral vascular disease; **or**
	052	Patient is immunocompromised.

Drug	Code	Criteria
Suboxone® *(buprenorphine-/naloxone)*	019	Before this code is allowed, the patient must meet <u>all</u> of the following criteria. The patient: a) Is **16** years of age or older; b) Has a <u>DSM-IV-TR</u> diagnosis of opioid dependence; c) Is psychiatrically stable or is under the supervision of a mental health specialist; d) Is not abusing alcohol, benzodiazepines, barbiturates, or other sedative-hypnotics; e) Is not pregnant or nursing; f) Does not have a history of failing multiple previous opioid agonists treatments and multiple relapses; g) Does not have concomitant prescriptions of azole antifungal agents, macrolide antibiotics, protease inhibitors, phenobarbital, carbamazepine, phenytoin, and rifampin, unless dosage adjusted appropriately; and h) Is enrolled in a state-certified intensive outpatient chemical dependency treatment program. See WAC 388-805-610. **Limitations:** • No more than 14-day supply may be dispensed at a time; • Urine drug screens for benzodiazepines, amphetamine/ methamphetamine, cocaine, methadone, opiates, and barbiturates must be done before each prescription is dispensed. ***The prescriber must fax the pharmacy with confirmation that the drug screen has been completed to release the next 14-day supply. The fax must be retained in the pharmacy for audit purposes;*** • Liver function tests must be monitored periodically to guard against buprenorphine-induced hepatic abnormalities; and • Clients may receive up to 6 months of buprenorphine treatment for detoxification and stabilization. **Note:** A Buprenorphine-Suboxone Authorization Form (DSHS 13-720) must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:** http://www1.dshs.wa.gov/msa/forms/eforms.html.
Symbyax® *(olanzapine/ fluoxetine HCl)*	048	All of the following must apply: a) Diagnosis of depressive episodes associated with bipolar disorder; and b) Patient is **6** years of age or older.

Drug	Code	Criteria
Talacen® *(pentazocine HCl/ acetaminophen)* **Talwin NX**® *(pentazocine/nalo xone)*	091	Patient must be **12** years of age or older and has tried and failed two NSAIDs or failed one other narcotic analgesic and is allergic or sensitive to codeine.
Toprol XL® *(metoprolol succinate)*	057	Diagnosis of congestive heart failure.
Topamax®**/ Topamax**® **Sprinkle** *(topiramate)*	036	Treatment of Seizures.
	045	Migraine prophylaxis.
Vancomycin oral	069	Diagnosis of clostridium difficile toxin and one of the following: a) The patient has failed to respond after 2 days of metronidazole treatment; or b) The patient is intolerant to metronidazole; or c) Metronidazole is contraindicated due to drug-drug interaction(s).
Vitamin E	105	Confirmed diagnosis of tardive dyskinesia or is clinically necessary for Parkinsonism and all of the following: a) Caution is addressed for concurrent anticoagulant treatment; and b) Dosage does not exceed 3,000 IU per day.
Wellbutrin SR® **and XL**® *(bupropion HCl)*	014	Treatment of depression.

Drug	Code	Criteria
Zofran® *(ondansetron HCl)*		See criteria for Kytril®.
Zolpidem	006	Treatment of insomnia. Limited to a 30 units per 30 day supply on initial fill, and 10 units per 30 days on all subsequent fills.
Zometa® *(zoledronic acid)*	011	Diagnosis of Hypercalcemia associated with malignant neoplasms with or without metastases; or multiple myeloma; or bone metastases of solid tumors.
Zyprexa® IM Injection *(olanzapine)*	060	All of the following must apply: a) Diagnosis of acute agitation associated with psychotic disorder, including bipolar disorder; b) Before any subsequent doses are given, patient has been evaluated for postural hypotension and no postural hypotension is present; c) Patient is 18 to 65 years of age; and d) Maximum dose of 30 mg in a 24 hour period.
Zyvox® Injectable *(linezolid)*	013	Treatment of vancomycin resistant infection.
Zyvox® Oral *(linezolid)*	013	Treatment of vancomycin resistant infection
	016	Outpatient treatment of methacillin resistant staph aureaus (MRSA) infections when IV vancomycin is contraindicated, such as: a) Allergy; or b) Inability to maintain IV access.

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Washington Preferred Drug List

What is the Washington Preferred Drug List?

HRSA, in coordination with the Health Care Authority (HCA) and Labor & Industries (L & I), have developed a list of preferred drugs within a selected therapeutic class that are selected based on clinical evidence of safety, efficacy, and effectiveness.

HRSA requires pharmacies to obtain prior authorization for nonpreferred drugs when a therapeutic equivalent is on the preferred drug list(s) (PDL).

> **Note:** HRSA changed the format for multiple drug listings. A slash (/) is used to denote multiple forms of a drug. For example: "Cardizem® /CD/LA/SR" represents immediate release Cardizem, as well as the CD, LA, and SR forms. A hyphen (-) is used to indicate combination products. For example: "Benazepril-HCTZ" represents the combination product of Benazepril and Hydrochlorothiazide, rather than Benazepril AND the combination product.

Drug Class	Preferred Drugs	Nonpreferred Drugs
ACE Inhibitors	**Generic:** benazepril captopril enalapril lisinopril **Brand:** Altace® (*ramipril*)* *EPA required	**Generic:** fosinopril moexipril quinapril **Brand:** Accupril® (*quinapril*) Aceon® (*perindopril*) Capoten® (*captopril*) Lotensin® (*benazepril*) Mavik® (*trandolapril*) Monopril® (*fosinopril*) Prinivil® (*lisinopril*) Univasc® (*moexipril*) Vasotec® (*enalapril*) Zestril® (*lisinopril*)

Drug Class	Preferred Drugs	Nonpreferred Drugs
Antiemetics	**Generic:** ondansetron injection/IV* **Brand:** Zofran® /ODT® (*ondansetron)** tablet/solution *EPA required	**Generic:** ondansetron tablet/solution* **Brand:** Aloxi® (*palonosetron)* injection* Anzemet® (*dolasetron*) tablet/injection* Kytril® (*granisetron*) tablet/solution/injection* Zofran® (*ondansetron)* injection/IV* *EPA required
Antiplatelets (*Not subject to therapeutic interchange program (TIP). See pg. M.1.)	**Generic:** clopidogrel* **Brand:** Aggrenox® (*dipyridamole/aspirin ER*)* Plavix® (*clopidogrel bisulfate*)* *EPA required	**Generic:** ticlopidine **Brand:** Ticlid® (*ticlopidine*)

Drug Class	Preferred Drugs	Nonpreferred Drugs
Attention Deficit/ Hyperactivity Disorder (*Not subject to TIP. See pg. M.1.)	**Generic:** amphetamine salt combo dextroamphetamine dextroamphetamine SA methylphenidate methylphenidate SA Methylin® (*methylphenidate HCl*) tablet Methylin ER® *(methylphenidate HCl)* **Brand:** Adderall XR® *(amphetamine salt combo)* Concerta® *(methylphenidate HCl)* Strattera® *(atomoxetine HCl)*	**Generic:** pemoline **Brand:** Adderall® *(amphetamine salt combo)* Daytrana™ (*methylphenidate HCl*) transdermal patch** Dexedrine® *(d-amphetamine)* Dexedrine SA® *(d-amphetamine)* Dextrostat® *(d-amphetamine)* Focalin® *(dexmethylphenidate)* Focalin XR® *(dexmethylphenidate)* Metadate CD™ *(methylphenidate HCl)* Metadate ER™ *(methylphenidate HCl)* Methylin® *(methylphenidate HCl)* chewable/solution Ritalin® *(methylphenidate HCl)* Ritalin LA® (*methylphenidate HCl)* Ritalin SR® *(methylphenidate HCl)* Vyvanse™ (*lisdexamfetamine dimesylate*)** **Not subject to DAW-1 override.

Drug Class	Preferred Drugs	Nonpreferred Drugs
Atypical Antipsychotic Drugs (*Not subject to TIP. See pg. M.1.)	**Generic:** clozapine tablet **Brand:** Abilify® (*aripiprazole*) tablet/solution/Discmelt® Fazaclo® (*clozapine*) disintegrating tablet Geodon® *(ziprasidone HCl)* capsule Geodon® (*ziprasidone mesylate*) IM injection* Risperdal® *(risperidone)* tablet/M-tab® Risperdal Consta® *(risperidone)* injection* Seroquel® (*quetiapine*) tablet Zyprexa® *(olanzapine)* tablet/ Zydis® Zyprexa® *(olanzapine)* IM injection* Zyprexa Zydis® *(olanzapine)* tablet *EPA required	**Generic:** **Brand:** Abilify® (*aripiprazole*) IM injection** Clozaril® (*clozapine*) tablet Invega™ (*paliperidone*) tablet** ** Not subject to DAW-1 override.

Drug Class	Preferred Drugs	Nonpreferred Drugs
Beta Blockers	**Generic:** atenolol metoprolol tartrate nadolol propranolol timolol **Brand:** Coreg® *(carvedilol)** Toprol XL (*metoprolol succinate*)* *EPA required	**Generic:** acebutolol betaxolol bisoprolol labetalol pindolol propranolol ER **Brand:** Blocadren® *(timolol)* Cartrol® *(carteolol)* Coreg CR® (*carvedilol CR*)** Corgard® *(nadolol)* Inderal® /LA *(propranolol)* Innopran XL® *(propranolol)* Kerlone® *(betaxolol)* Levatol® *(penbutolol)* Lopressor® *(metoprolol tartrate)* Normodyne® *(labetalol)* Sectral® *(acebutolol)* Tenormin® *(atenolol)* Trandate® *(labetalol)* Visken® *(pindolol)* Zebeta® *(bisoprolol)* **Not subject to TIP or DAW-1 override.

Drug Class	Preferred Drugs	Nonpreferred Drugs
Calcium Channel Blockers	**Generic:** amlodipine diltiazem /XR felodipine nifedipine ER verapamil /XR	**Generic:** felodipine nicardipine nifedipine **Brand:** Adalat® /CC (*nifedipine*) Calan® /SR (*verapamil*) Cardene® /SR (*nicardipine*) Cardizem® /CD/LA/SR (*diltiazem*) Cartia XT® (*diltiazem*) Dilacor® XR (*diltiazem*) Diltia XT® (*diltiazem*) DynaCirc® /CR (*isradipine*) Isoptin® /SR (*verapamil*) Norvasc® (*amlodipine*) Plendil® (*felodipine*) Procardia® /XL (*nifedipine*) Sular® (*nisoldipine*) Taztia XT® (*diltiazem*) Tiazac® (*diltiazem*) Vascor® (*bepridil*) Verelan® /PM (*verapamil*)
Drugs to treat Alzheimer's Disease (*Not subject to TIP. See pg. M.1.)	**Brand:** Aricept® /ODT(*donepezil*) Exelon® (*rivastigmine*) Razadyne® /ER(*galantamine*) Namenda™ (*memantine*)	**Brand:** Cognex® (*tacrine*)

Drug Class	Preferred Drugs	Nonpreferred Drugs
Estrogens	**Generic:** estradiol tablets **Brand:** Menest® (*esterified estrogens*) Premarin® cream (*conjugated equine estrogen vaginal cream*)	**Generic:** estradiol transdermal patch estropipate **Brand:** Alora® (*estradiol*) transdermal Cenestin® (*synthetic conjugated estrogens*) Climara® (*estradiol*) transdermal Elestrin™ (*estradiol*) gel** Esclim® (*estradiol*) transdermal Estrace® (*estradiol*) oral/vaginal Estraderm® (*estradiol*) transdermal Estring® (*estradiol*) vaginal ring Femring® (*estradiol*) vaginal ring Femtrace® (*estradiol*) tablet** Ogen® (*estropipate*) Premarin® (*conjugated equine estrogens*) oral Vagifem® (*estradiol*) vaginal tablets Vivelle® /DOT (*estradiol*) transdermal **Not subject to TIP or DAW-1 override.
Hepatitis C drugs (pegylated interferons)	Pegasys® *(peginterferon alfa-2a)*	PegIntron® *(peginterferon alfa-2b)*
Histamine-2 Receptor Antagonist (H2RA) (*Not subject to TIP. See pg. M.1.)	**Generic:** ranitidine	**Generic:** cimetidine famotidine nizatidine **Brand:** Axid® (*nizatidine*) Pepcid® (*famotidine*) Tagamet® (*cimetidine*) Zantac® (*ranitidine*)

Drug Class	Preferred Drugs	Nonpreferred Drugs
Inhaled Beta-Agonists	**Generic short-acting nebulized:** albuterol inhalation solution metaproterenol inhalation solution **Brand short-acting nebulized:** Xopenex® (*levalbuterol*) inhalation solution **Generic short-acting inhaled:** albuterol inhaler **Brand short-acting inhaled:** Alupent® (*metaproterenol*) inhaler Ventolin® HFA (*albuterol*) inhaler Xopenex® HFA (*levalbuterol*) inhaler **Brand long-acting :** Foradil® Aerolizer® (*formoterol*) Serevent® Diskus® (*salmeterol*)	**Brand short-acting nebulized:** Accuneb® (*albuterol*) inhalation solution Proventil® (*albuterol*) inhalation solution **Brand short-acting inhaled:** Maxair Autohaler™ (*pirbuterol*) inhaler ProAir™ HFA (*albuterol*) inhaler Proventil® (*albuterol*) inhaler Proventil® HFA (*albuterol*) inhaler **Brand long-acting (nebulized):** Brovana™ (*arformoterol*)** **Not subject to TIP or DAW-1 override.
Inhaled Corticosteroids	**Generic:** **Brand:** Aerobid/Aerobid-M® (*flunisolide MDI*) Asmanex Twisthaler® (*mometasone fumarate DPI*) Azmacort® (*triamcinolone acetonide MDI*) Flovent® /HFA/Rotadisk® (*fluticasone propionate MDI/HFA/DPI*) Qvar® (*beclomethasone dipropionate MDI*) Pulmicort Respules® (*budesonide inhalation suspension*) Pulmicort Turbuhaler®/Flexhaler® *(budesonide DPI)*	**Generic:** **Brand:** Vanceril® *(beclomethasone dipropionate MDI)*

Drug Class	Preferred Drugs	Nonpreferred Drugs
Insulin-release stimulant type oral hypoglycemics	**Generic immediate release:** glipizide glyburide glyburide micronized	**Generic:** chlorpropamide glimepiride glipizide XR tolazamide tolbutamide **Brand:** Amaryl® (*glimepiride*) Diabinese® (*chlorpropamide*) DiaBeta® (*glyburide*) Glucotrol® /XR (*glipizide*) Glynase® (*glyburide micronized*) Micronase® (*glyburide*) Orinase® (*tolbutamide*) Prandin® (*repaglinide*) Starlix® (*nateglinide*) Tolinase® (*tolazamide*)
Long-Acting Opioids (oral tabs/caps/liquids) (*Not subject to TIP. See pg. M.1.)	**Generic:** methadone morphine sulfate /SA/SR	**Generic:** fentanyl transdermal levorphanol oxycodone ER Oramorph® SR **Brand:** Avinza® *(morphine sulfate ER)* Dolophine® (*methadone*) Duragesic® *(fentanyl)* transdermal Kadian® *(morphine sulfate SR)* Kadian® 200mg (*morphine sulfate SR*)** Levo-Dromoran® *(levorphanol)* MS Contin® *(morphine sulfate SA)* Opana ER® *(oxymorphone HCl)* OxyContin® *(oxycodone ER)* **Not subject to DAW-1 or EPA overrides due to safety concerns (to prevent potential error/overdose).

Drug Class	Preferred Drugs	Nonpreferred Drugs
Macrolides (*Not subject to TIP. See pg. M.1.)	**Generic:** azithromycin – all forms clarithromycin immediate release tablet/suspension erythromycin EC erythromycin ethylsuccinate erythromycin filmtab erythromycin stearate **Brand:** Ery-Tab 333mg® *(erythromycin base EC)*	**Generic:** **Brand:** Biaxin® *(clarithromycin)* tablet/suspension Biaxin XL® *(clarithromycin)* EES® *(erythromycin ethylsuccinate)* granules/suspension/filmtab Eryc® *(erythromycin base EC)* E-Mycin® *(erythromycin base)* Eryped® *(erythromycin ethylsuccinate)* drops/granules/chewable tablets Ery-Tab® *(erythromycin base EC)* Erythrocin® *(erythromycin stearate)* filmtab PCE Dispertab® *(erythromycin base)* Zithromax® (*azithromycin)* capsule/powder packet/suspension/tablet Zmax® *(azithromycin SR)*
Nasal Corticosteroids	**Generic:** **Brand:** Nasacort AQ® *(triamcinolone acetonide)* Nasonex® (*mometasone furoate*)* *EPA required	**Generic:** flunisolide fluticasone propionate **Brand:** Beconase /AQ® *(beclomethasone dipropionate)* Flonase® *(fluticasone propionate)* Nasacort® *(triamcinolone acetonide)* Nasarel® *(flunisolide)* Rhinocort® (*budesonide*) Rhinocort /Aqua® (*budesonide*) Vancenase /AQ® (*beclomethasone dipropionate)* Veramyst™ (*fluticasone*)** **Not subject to DAW-1 override or TIP.

Drug Class	Preferred Drugs	Nonpreferred Drugs
Newer Antihistamines (formerly Non-Sedating Antihistamines)	**Generic:** loratadine OTC **Brand:** Clarinex® *(desloratadine)* syrup* *EPA required	**Generic:** fexofenadine **Brand:** Allegra® (*fexofenadine*) Clarinex® (*desloratadine*) Claritin® (*loratadine*) Zyrtec® (*cetirizine*)
Newer Sedative/Hypnotics	**Generic:** zolpidem* *EPA required	**Brand:** Ambien /CR® *(zolpidem tartrate)** Lunesta® *(eszopiclone)** Sonata® *(zaleplon)** *EPA required
Nonsteroidal anti-inflammatory drugs (NSAID) including Cyclo-oxygenase - 2 (Cox-II) Inhibitors	**Generic:** diclofenac potassium* diclofenac sodium /SR/ER/EC* diflunisal* etodolac /XL* fenoprofen* flurbiprofen* ibuprofen* indomethacin /SA* ketoprofen /SA* ketorolac* meclofenamate* meloxicam* nabumetone* naproxen /EC* naproxen sodium /ER* oxaprozin* piroxicam* salsalate* sulindac* tolmetin* *EPA required	**Generic:** **Brand:** Amigesic® (*salsalate*)* Anaprox® /DS (*naproxen sodium*)* Ansaid® (*flurbiprofen*)* Cataflam® (*diclofenac potassium*)* Celebrex® (*celecoxib*)* Clinoril® (*sulindac*)* Dolobid® *(diflunisal)* Daypro® (*oxaprozin*)* Feldene® (*piroxicam*)* Indocin® /SR (*indomethacin*)* Lodine® /XL (*etodolac*)* Mobic® (*meloxicam*)* Motrin® (*ibuprofen*)* Nalfon® (*fenoprofen*)* Naprelan® (*naproxen sodium ER*)* Naprosyn® EC/DS (*naproxen*)* Orudis® (*ketoprofen*)* Oruvail® (*ketoprofen SA*)* Ponstel® (*mefenamic acid*) Relafen® (*nabumetone*)* Salflex® (*salsalate*)* Toradol® (*ketorolac*)* Voltaren® /XR (*diclofenac sodium*)* *EPA required

Drug Class	Preferred Drugs	Nonpreferred Drugs
Overactive Bladder/Urinary Incontinence	**Generic short acting:** oxybutynin chloride tablets/syrup **Brand long acting:** Vesicare® *(solifenacin succinate)*	**Generic short acting:** flavoxate HCl **Brand short acting:** Detrol® *(tolterodine tartrate)* Ditropan® *(oxybutynin chloride)* Sanctura® *(trospium chloride)* Urispas® *(flavoxate HCl)* **Brand long acting:** Detrol LA® *(tolterodine tartrate)* Ditropan XL® (*oxybutynin chloride)* Enablex® *(darifenacin hydrobromide)* Oxytrol® *(oxybutynin chloride)*
Proton Pump Inhibitors	**Generic:** Prilosec OTC® *(omeprazole)* tablets Prevacid® *(lansoprazole)* capsules Prevacid® SoluTab *(lansoprazole)** Prevacid® Suspension *(lansoprazole)** *EPA required	**Generic:** omeprazole Rx **Brand:** Aciphex® *(rabeprazole)* Nexium® *(esomeprazole)* Prilosec® Rx *(omeprazole)* Protonix® *(pantoprazole)* Zegerid® *(omeprazole)*
Second Generation Antidepressants (*Not subject to TIP. See pg. M.1.)	**Generic:** bupropion /SR* citalopram fluoxetine HCl mirtazapine/soltab paroxetine HCl venlafaxine HCl **Brand:** Effexor® /XR (*venlafaxine HCl*) *EPA required	**Generic:** fluvoxamine nefazodone sertraline **Brand:** Celexa® (*citalopram*) Cymbalta® (*duloxetine HCl*) Lexapro® (*escitalopram*) Luvox® (*fluvoxamine*) Paxil® /CR (*paroxetine HCl*) Pexeva® (*paroxetine mesylate*) Prozac® /Prozac Weekly® (*fluoxetine HCl*) Remeron® /SolTab (*mirtazapine*) Serzone® (*nefazodone*) Wellbutrin® /SR/XL (*bupropion/SR/XL*) Zoloft® (*sertraline*)

Drug Class	Preferred Drugs	Nonpreferred Drugs
Skeletal Muscle Relaxants	**Generic:** baclofen cyclobenzaprine methocarbamol tizanidine	**Generic:** carisoprodol chlorzoxazone orphenadrine tizanidine **Brand:** Dantrium® (*dantrolene*) Flexeril® (*cyclobenzaprine*) Lioresal® (*baclofen*) Norflex® (*orphenadrine*) Parafon Forte® (*chlorzoxazone*) Robaxin® (*methocarbamol*) Skelaxin® (*metaxalone*) Soma® (*carisoprodol*) Zanaflex® (*tizanidine*)
Statin-type cholesterol-lowering agents	**Generic:** lovastatin pravastatin* **Brand:** Crestor® (*rosuvastatin*) *EPA required	**Generic:** simvastatin **Brand:** Lescol® /XL (*fluvastatin*) Lipitor® (*atorvastatin*) Mevacor® (*lovastatin*) Pravachol® (*pravastatin*)* Zocor® (*simvastatin*)
Targeted Immune Modulators (*Not subject to TIP. See pg. M.1.)	**Generic:** **Brand:** Enbrel® (*etanercept)** Humira® *(adalimumab)** Remicade® (*infliximab)** *EPA required	**Generic:** **Brand:** Amevive® *(alefacept)** Kineret® *(anakinra)** Orencia® *(abatacept)** Raptiva® *(efalizumab)** Rituxan® *(rituximab)** *EPA required
Thiazolidinediones (TZDs)	**Generic:** **Brand:** Avandia® tablet (*rosiglitazone maleate*)	**Generic:** **Brand:** Actos® tablet (*pioglitazone HCl*)

Drug Class	Preferred Drugs	Nonpreferred Drugs
Triptans	**Generic:** **Brand:** Imitrex® (*sumatriptan*) tablet/nasal spray/injection Relpax® (*eletriptan*) Zomig® (*zolmitriptan*) tablet/nasal spray/ZMT®	**Generic:** **Brand:** Amerge® (*naratriptan*) Axert® (*almotriptan*) Frova® (*frovatriptan*) Maxalt® (*rizatriptan*) tablet/MLT®